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APRIL 14th, 1895.

*"Æquum memento rebus in arduis
Servare mentem."—Horace, Book ii, Ode iii.*

Notes on Aseptic Surgery.

By C. B. LOCKWOOD, F.R.C.S.,
Assistant Surgeon to the Hospital.

(Continued from page 83.)

THE commonest bacteria have now been described. I have also mentioned where they are found, and how they enter wounds. The next step is to tell how to keep them out of wounds.

This requires a knowledge of disinfection and of antiseptics. An antiseptic has already been defined as that which prevents or retards the growth of bacteria, and a disinfectant as that which kills them outright. These distinctions must now be kept clearly in mind.

Disinfection may be carried out by heat, chemicals, or by filtration. Sunlight, electricity, and some mechanical processes might also be enumerated, but have not the same value as the others. Nevertheless, in planning hospitals the value of sunlight ought not to be ignored. It has the most potent influence upon bacteria, in preventing or retarding their growth, and in purifying the atmosphere. Later it will

be seen that mechanical measures, such as scrubbing, are an important part of the disinfection of the skin.

Of all methods of disinfection heat is the simplest, cheapest, and best. Chemicals occupy the second rank, but are treacherous and difficult to use. Filtration by Chamberland's filter, or Berkefeld's modification of it, may be of occasional use for the sterilisation of water. This, however, is done more easily and certainly by heat.

The practice of aseptic surgery does not consist in the slavish use of chemicals. They are merely adjuncts, and not an essential part of the system. Some surgeons try to do without chemicals. They pin their faith upon heat in its various forms for the elimination of bacteria.

It is, perhaps, doubtful what the practice of the future will be. As our hospitals are at present constituted, chemicals can hardly be avoided. Some time since, Mr. Butlin* treated his cases with a minimum of chemicals, and with materials sterilised with heat. Out of sixty-one cases, twenty-nine suppurated. Bloch,† too, seems to have pursued the same system with moderate success. The results of the mixed method of asepsis, which, as I have already said, utilises both heat and chemicals, has given me in hospital practice about six per cent. of suppuration. But much of this was trivial and not progressive. Moreover, as house surgeons, dressers, sisters, and nurses acquire the principles of aseptic surgery, the proportion of suppuration tends to diminish.

Disinfection by heat is governed by certain laws. First, all cocci and non-spore-bearing bacilli are easily killed by moderate heat acting for a short time. Second, spores are only killed by considerable degrees of heat acting for a long time. Third, moist heat is much more efficacious than dry heat; and fourth, fluids of small nutritive value are easier to disinfect than those of high nutritive value. Thus water is easier to disinfect than urine, and urine is easier to disinfect than milk, or blood, or sputum.

Generally speaking, a high degree of dry heat kills bacteria quicker than a lower degree, and the same applies to moist heat.

* *St. Bartholomew's Hospital Reports*, vol. xxix, 1893, p. 89, *et seq.*

† *Revue de Chirurgie*, 1890.

Pasteur and others have found it easier to kill bacteria in acid media. In some alkaline fluids the bacteria seem to be in some way protected against heat,—as, for example, in milk.*

Heat may be used as a disinfectant either as dry heat, steam, or boiling water.

Dry heat is used in the laboratory for disinfecting platinum wires, instruments, glass vessels, and cotton wool. We do not, however, use it much for the disinfection of surgical appliances. To obtain reliable results a temperature of 180° C. for at least thirty minutes is required. Koch ascertained that sporeless bacteria were destroyed by exposure for an hour and a half to hot air at a temperature slightly exceeding 100° C. The spores of bacilli such as anthrax required three hours at 140° C.†

The chief spore-bearing bacilli which surgeons have to fear are anthrax, tetanus, tubercle, and *Bacillus septicus*. Yersin killed spore-bearing tubercle bacilli in ten minutes with water at a temperature of 70° C. The bacilli were heated in glycerine broth in which they had grown.‡ To kill tubercle bacilli in sputum a temperature of 100° C. acting for at least five minutes is needed. Presently the resistance of tetanus spores will be mentioned.

The high temperature which is required to ensure sterility by dry heat is not easy to attain. Moreover dry heat coagulates blood, pus, or serum in the joints and crevices of instruments. It is possible that the coagulation itself may protect the bacteria from the heat. Then such substances may remain a dangerous source of infection, being rubbed off when the instruments are used.

Moreover the high temperature of dry heat is harmful to cutting instruments, especially the finer kinds of knives and scissors. Dry heat also requires a special apparatus.

Therefore we use boiling water for the sterilisation of instruments, silk, drainage-tubes, fishing-gut, towels, and utensils. An expensive apparatus is unnecessary. A large enamelled stewing-pan can be purchased for a few shillings. In hospitals where quantities of appliances are required it may be desirable to provide a large steam steriliser and a large copper pan, but this is chiefly a matter of convenience.

Steam and boiling water are very efficient disinfectants. Kitasato found that tetanus spores bore a temperature of 80° C. for half an hour to an hour, but were killed in five minutes in the steam steriliser at 100° C. They were still virulent after ten hours' immersion in 5 per cent. carbolic lotion, but fifteen hours killed them. A solution of perchloride of mercury, one part in one thousand parts of water, with 5 per cent. of hydrochloric acid, killed them in

thirty minutes, although the same strength of perchloride without the acid took three hours.

Koch and his co-workers, Gaffky and Loeffler, killed anthrax spores in five minutes with steam at the pressure of the atmosphere. Von Esmarch killed them by the same means in from three to twelve minutes. Vinay says they are killed by steam in two or three minutes, and Sternberg found they did not grow after four minutes' exposure to 100° C.

The spores which Vinay tested were alive after soaking for thirty-seven days in 5 per cent. carbolic lotion.*

All the pyogenic cocci are easier to kill with either dry or moist heat, but *Staphylococcus aureus* was only killed by an hour's exposure to a dry heat of 80° C.† Sternberg showed that moist heat at 100° C. killed *Staphylococcus aureus* in a minute and a half.

Some of the spores met with in earth have, however, extraordinary powers of resisting heat. The spores of hay bacillus resisted steam at 100° C. for two hours and a half,‡ and Courboulès§ found that a temperature of 120° C. was required to kill the spores of the *Bacillus septicus*. This last is, as I have said before, pathogenic for man and animals. Arloing dried and powdered the muscles of animals which had died of anthrax. The virulence of this powder was not destroyed by steam at 100° C. after six hours. It is improbable that the steam reached the anthrax, but the experiment shows how hard it is under certain conditions to disinfect.

In reading the literature of disinfection by heat a good many discordant statements are met with, and the subject seems to require further elucidation.

In difficult circumstances disinfection can only be attained in a short time by using superheated steam. There is no other reliable way of disinfecting clothing, bedding, and the like. In surgery, however, we seldom have to deal with such resistant spores as those of anthrax and gaseous gangrene, nor with such difficult things to disinfect as clothing or bedding. Should, however, the presence of resistant spores be suspected extra precautions should be taken.

It is universally acknowledged that the pyogenic cocci, such as *Streptococcus pyogenes* and *Staphylococcus aureus*, and most of the bacilli met with in wounds, are not more resistant to moist heat than non-spore-bearing anthrax bacilli. Most adult pathogenic germs perish after ten minutes' exposure to 64° C. of moist heat (Vinay). It is, therefore, certain that all non-spore-bearing bacilli and all cocci will be killed by five minutes' sojourn in boiling water. The occasional presence of spores must, however, be taken into

* Manuel d'Asepsie, la Stérilisation et la Disinfection par Chaleur, Paris, 1890, p. 56. This work gives much useful information.

† Vinay, loc. cit., p. 39.

‡ Koch and Wölffhügel, *Micro-parasites in Disease*, New Sydenham Soc., 1886, p. 525.

§ A method of staining the spores of tubercle bacilli seems to be needed. Its discovery would be a great advance.

‡ "Notiz über die Widerstandsfähigkeit der Sporen von *Bacillus subtilis* gegen Wasserdampf von 100° C.," Max Gruber, *Centralblatt für Bacteriologie*, 1888, vol. iii, p. 576.

§ Quoted by Vinay, p. 62.

consideration. Fifteen minutes in boiling water is enough to kill such as are likely to be met with. A good deal depends, however, upon the thoroughness with which the bacteria or spores are exposed to the heat. For instance, Koch* found that "steam generated at the bottom of a deep vessel had a temperature of 70° C. to 78° C. one centimetre above the surface of the boiling water; while in a shallow vessel, in which the steam mixed readily with the air, the temperature at a similar level was 10° C. lower than this." Such a source of error can be overcome by covering the articles with the boiling liquid.

It is advantageous to add a tea-spoonful of washing soda to each pint of the water used for disinfecting instruments. The soda helps the removal of grease and fat, and prevents the instruments from rusting. Moreover the addition of the soda renders the boiling-point of the water a little higher, so that disinfection is more certain and rapid.

Dry heat penetrates such substances as silk, towels, glass, or india rubber very slowly, and moist heat takes some time to penetrate them thoroughly. Thus, if a little silk be wound upon a reel for disinfection, time ought to be allowed for penetration; and if much is wound on, a considerable time may be needed before the deeper layers are sterilised.

Before being placed in the steam steriliser or in hot water, towels, or similar things, should be opened out or unrolled. The experiments of Koch, Gaffky, and Loeffler,† and of Parsons, clearly showed that heat took a long time to reach the centre of rolls of cloth. A roll of coarse black cloth, 25 cm. by 8 cm., was exposed to superheated steam, which in thirty minutes reached 120° C. The temperature at the centre of the roll had not at the end of the half-hour risen to 65° C., but the steam being raised to 126° C., and kept at that temperature for thirty minutes more, the temperature of the cloth rose to 118° C. When first I began to sterilise towels with steam several failures occurred, because we omitted to unfold the towels before putting them in the steriliser. For ordinary purposes the simplest kind of steam steriliser is all that is required. We have obtained excellent results by using one made of copper and arranged like an ordinary potato steamer. I have no doubt but that an ordinary potato steamer would answer perfectly. It is advantageous to have a small hole in the top of the lid of the steriliser for a thermometer. Unless all the air is expelled before use the steam in the sterilising chamber does not attain its highest temperature.

Before leaving disinfection by heat, perhaps I ought to say that cold has hardly any power of disinfection. Sternberg‡ quotes Frisch's experiments in which micrococci and bacilli grew after exposure to -87° C., and Prudden's in which freezing for sixty-six days did not kill *Staphylococcus aureus*.

(To be continued.)

* Loc. cit., *Disinfection by Steam*, p. 529.

† New Sydenham Soc. trans., 1886, translated by Dr. Whitelegge.

‡ P. 145.

Notes on Paralysis of the Upper Extremity.

By H. LEWIS JONES, M.D.,

Medical Officer in charge of the Electrical Department.

(Continued from page 87.)

THE DELTOID.—Paralysis of this muscle from injury or dislocation of the shoulder-joint is one of the most common forms of paralysis in the upper extremity.

In the note-books of the Electrical Department a very large number of cases are recorded. The deltoid is also subject to paralysis from neuritis of the circumflex nerve apart from injury. I have notes of a case where it followed parturition, and of another after a feverish attack with bronchitis, and two occurring after typhoid fever. The condition of pain in the shoulder called deltoid rheumatism is a neuritis affecting the circumflex nerve, and may lead to paralysis and wasting of the deltoid muscle; such cases are not uncommon.

The circumflex nerve is exposed to injury in its course through the muscle, and its trunk may also be strained in dislocations, or it may be compressed by a crutch or axillary pad. The teres minor suffers with the deltoid when the injury is to the trunk of the nerve; when the injury is in the intra-muscular part it may escape. It is not always easy to determine the state of the teres minor by electrical testing, as it is so much covered by other muscles, nor by observing the voluntary movements of the patient, as its functions can be adequately performed by the infra-spinatus. The attempt to ascertain its condition, however, should always be made.

The spinati are often paralysed by the injury which paralyses the deltoid.

The flattened appearance of the shoulder, and the prominence of the acromial process of the scapula make it easy to recognise paralysis of the deltoid, unless the subject be very stout. In infants also the adipose tissue which covers the shoulder may mask the wasting of the muscle. When the wasting and paralysis are extreme the head of the humerus is no longer held up in the glenoid cavity, but can be seen and felt to hang loosely in a state of partial dislocation, and to be freely moveable in its socket. One may even be able to push the tip of a finger between the acromion and the head of the humerus. In cases of paralysis of the deltoid it is not uncommon to find some adhesions or creaking in the shoulder-joint; for an injury of the circumflex nerve may produce paralysis of the muscle and changes in the articular surfaces. In examining a patient who complains of weakness in the shoulder it is useful to bear this in mind, and to test the condition of the deltoid, for otherwise the case may be regarded as one of primary arthritis of the joint when the articular mischief is in reality secondary to injury or disease of the circumflex nerve.

When the deltoid is paralysed the arm cannot be raised to the horizontal position, and the utility of the limb is very seriously diminished for a large number of movements, because there is no other muscle able to supplement it to any appreciable extent; the supra-spinatus has a similar function to the deltoid, but it is too feeble to be able to raise the weight of the arm. It sometimes happens that part only of the deltoid is paralysed; I have notes of three cases. In one the patient had had suppuration round the shoulder, and an incision for the evacuation of the pus was made on the posterior aspect of the joint. One of the branches of the circumflex nerve was injured, and the posterior half of the muscle was wasted, and showed a partial reaction of degeneration. Under electrical treatment combined with daily rubbing the muscle recovered.

The deltoid is rather apt to suffer in infantile paralysis of the upper limb, and the chances of its recovery in this disease are not good. I have known a paralysis of this muscle persist as the remnant of an extensive paralysis of the whole upper limb, and in other cases have found it most difficult to stimulate any new growth of muscle-fibres in the deltoid, even after months of persevering electrical treatment. This may mean that the nucleus of origin of the fibres which supply the deltoid is a small circumscribed one, and easily destroyed, or that the muscle, working as it does at great mechanical disadvantage, cannot afford the loss even of a portion of its fibres without serious impairment of its powers.

In one of my infantile cases the posterior third of the deltoid has grown again under treatment into a fairly strong muscular bundle, the rest of the muscle remaining quite wasted.



FIG. 4.—Paralysis and atrophy of right deltoid.

In the ordinary traumatic paralysis of the deltoid the prognosis is more favourable. The majority of the cases recover, but there is a considerable minority which do not, and on this account it is wise to express a guarded opinion when there is much wasting and a reaction of degeneration, and the prognosis must be made to depend upon the behaviour of the muscle under treatment. If the electrical reactions are normal, or show only a quantitative change, or the partial reaction of degeneration, the prognosis is more favorable. Taken generally, the deltoid may be said to be a muscle which is easily damaged, and has not a very great recuperative power. The presence of articular changes in a case of paralysis of the deltoid is unfavourable, though here also recovery may take place. The skin over the deltoid receives sensory fibres from the circumflex nerve, and impairment of sensation or anæsthesia is frequently to be found if looked for when the muscle is paralysed.

Combined paralyses of the upper limb.—It often happens that many of the muscles of the arm are paralysed together from injury or disease of the nerve-trunks. After a serious dislocation of the shoulder, and particularly if this has remained for some hours unreduced, there may be complete paralysis of the whole limb. Mr. Bowlby has published * several cases in which an injury had caused rupture of all the roots of the brachial plexus, but this is not a usual result of injuries or dislocations of the shoulder. A contraction of the pupil on the affected side has been noticed in some of these cases. If the spinal nerve-roots are actually torn out of the cord by the injury, laceration may occur of the fibres destined to emerge from the cord in the thoracic region to form the cervical sympathetic.

Several causes combine to produce extensive paralysis after a dislocation. The head of the humerus presses upon the brachial plexus in dislocations forward below the coracoid process, and so produces paralysis below that point; but this pressure will not cause paralysis of the muscles of the scapula, for these are supplied by branches given off higher up, and yet they are generally, if not always, implicated. It is possible that the upper cords of the plexus may be compressed between the clavicle and the vertebral column if the violence has tended to drive the shoulder backwards, for the shoulder has free play from the sterno-clavicular joint, and might be driven sufficiently far back to do this. Or the upper cords of the plexus may be more directly subjected to traction from the injury, or finally they may be damaged by the efforts employed in reducing the dislocation, and from their position and direction they are more likely than the lower roots of the plexus to suffer in this way.

It seems probable that the upper cords of the plexus are most likely to be injured by traction, either in the injury or in the efforts to reduce the dislocation; while the nerve-trunks of the arm are injured lower down by the pressure of

* *Injuries and Diseases of Nerves*, London, 1889, J. & A. Churchill.

the head of the bone against them. The subscapular nerves, by their position, and by the direction in which they run, are rather better protected than the other nerves from both these accidents; and this perhaps accounts for the frequent escape of the latissimus dorsi, the subscapularis, and the teres major muscles in extensive paralysis of the shoulder and arm from injury.

Erb's paralysis.—One particular type of combined paralysis affecting the muscles of the shoulder and arm has received this name, though in France it is often known as the Duchenne-Erb type, because Duchenne first drew attention to it, and reported five examples. He was unable to explain the peculiar association of certain muscles in these cases, and it was Erb who, in 1874, pointed out the anatomical reasons for this special grouping. The affected muscles are the biceps coraco-brachialis and brachialis anticus, which are supplied by the musculo-cutaneous nerve; the deltoid (circumflex nerve), and one muscle supplied by the musculo-spiral, namely, the supinator longus; often the spinati too (supra-scapular nerve) are involved. The affection of the supinator longus alone among the muscles supplied by the musculo-spiral nerve seems at first to be a perplexing feature, but it suggests the idea that the injury must be situated above the point at which the musculo-spiral nerve is built up. Erb pointed out that an injury limited to the two upper roots of the brachial plexus, the fifth and sixth cervical, or to their combined trunk, would produce the kind of paralysis under consideration; and further showed that these cords can be directly stimulated at a point in the neck one inch above the clavicle and a little external to the outer border of the sterno-mastoid. This is known as Erb's motor point, and by means of an electrode applied to it the muscles in question can be readily thrown into simultaneous contraction.

The existence of Erb's paralysis as a clinical unit depends upon the comparatively exposed position of these two nerve-roots, just as we have seen that paralyzes of some of the single muscles of the shoulder are common for the same reason, and varieties in the extent of the paralyzes exist according as the injury or disease affects chiefly the fifth or the sixth roots or their united trunk.

From the investigations of Ferrier, Herringham,* and others we have a fair knowledge of the levels at which the different components of the nerves of the upper limb leave the spinal cord. There is a certain amount of variation between individual cases, so that we cannot state absolutely that certain fibres run always in the fifth root, and certain others only in the sixth or seventh. Moreover many muscles receive their nerve-supply from more than one level; for example, the serratus magnus from the fifth, sixth, and seventh roots.

From what is known one would expect that a lesion of the fifth and sixth roots, or of their combined trunk, should

involve not only the muscles already mentioned, but also the rhomboids, the teres minor, the subclavius, the upper parts of the pectoralis major and serratus magnus, and the supinator brevis, and most of these muscles have been noted as involved in some of the recorded cases.

Although a large number of cases of this form of paralysis have been collected, it is not in all of them that a sufficiently minute examination of the muscles has been made. Further study of these cases, if carried out with proper care, is likely to advance our knowledge of the anatomical distribution of the fibres emerging at the upper levels of the brachial plexus.

It must be borne in mind that Erb's paralysis is not in the least a special form of disease. The name has the advantage of brevity alone. Any sort of injury or disease which is limited to the upper part of the brachial plexus will produce paralysis of the group of shoulder and arm muscles already mentioned. In particular, injuries to the child arising during difficult labour is a common cause, so that Duchenne described it as "obstetrical" palsy of the arm. Among twenty cases of which I have notes, seven were caused in this way, four followed injury, one was due to sarcoma of the cervical vertebrae, and in this, owing to extension of the disease, the paralysis was not long limited to the muscles of the Duchenne-Erb group. One was associated with an abscess in the neck, and the remainder came on gradually and were due to neuritis of some kind.



FIG. 5.—Paralysis of trapezius, deltoid, and spinati on right side.

All degrees of combined paralysis from the typical Duchenne-Erb type to complete paralysis of the shoulder and arm may be met with.

I have seen one case, typical in other ways, in which the

* *Proc. Roy. Soc.*, March, 1886.

deltoid was at no time affected, though the supinator longus and the three flexors were.

The triceps in some cases, and the extensors of the wrist in others, have been noted to be weak in cases of Erb's paralysis. In two cases I have noted some weakness of the upper part of the pectoralis major.

Infantile paralysis may sometimes resemble Erb's paralysis in its distribution, but it is not likely often to be confounded with it if the history of the case and the distribution of the paralysis be carefully taken into account. Fig. 5 is from a case of infantile paralysis, and shows wasting of the deltoid, spinati, and trapezius, the last only in its upper part.

(To be continued.)

On Hysterical or Functional Disorders.

By H. H. TOOTH, M.D.

Read before the Abernethian Society, October 25th, 1894.

TN attempting to discuss this evening the phenomena grouped under the term "hysterical" or functional disorders, I am fully alive to the extreme difficulty of the task. The difficulty consists largely in the fact that we are concerned with a vast aggregation of symptoms, definite enough of themselves, but of which we at present know no pathological or anatomical basis. Anatomy, gross and minute, has given us a grasp of organic diseases which fails us here. Here we have a department of medicine which is based on symptoms. That may be said of all branches of medicine, but with this important difference, that in organic disease the symptom is the mirror, which, if viewed correctly, reflects to the mind a picture of some anatomical condition. Thus the symptom hemiplegia suggests to the mind at once a lesion of the cerebral motor tract—a fact which has been verified over and over again post-mortem; but the same symptom in a "functional" case is a symptom and little more, pathology at present teaching us nothing about it, except that it is *not* this, that, or the other.

So necessary has it become to us to hang our ideas of disease upon the underlying anatomical facts, that, finding none in hysteria, we form mental comparisons between the phenomena of hysteria of which we know not the anatomical basis, and organic diseases so-called, of which we do. Thus has crept in, in our natural craving for classification, the idea of nervous mimicry, because the symptoms resemble those that we find in organic cases, the resemblance at best being only superficial.

It seems to me that the idea expressed in the term neuro-mimesis is in every way prejudicial to the study of functional affections. The term implies conscious or unconscious imitation, on the part of whom—the disease or the patient? If the latter, there creeps in the fatal error of supposing that in some way or other the patient is more or less responsible in producing and keeping alive the condition. Almost all the crude medical notions of the public have emanated from those of the medical profession in days gone by. The humoral pathology, for instance, still flourishes among the laity. Hence it is that the term "hysteria" is, with the public, often another name for shamming. The attitude of mind of a student of the multitudinous aspects of hysteria must be that of one studying a disease with a distinct pathology yet to be discovered.

Such has been the position taken up by the French School, with Charcot at its head, and I believe that the cause of humanity has been materially advanced by it.

Historical.—Gilles de la Tourette* quotes Plato as being responsible for the conception that hysteria is due to uterine trouble—an idea still

embodied in the name. He looked upon the uterus as an animal which ardently desired to engender children. If, after puberty, it remained sterile it ran about the body, obstructed the entrance of air, stopped respiration, and threw the body into extreme danger, and caused divers diseases.

In the middle ages the graver forms of hysteria were considered instances of demoniacal possession. As Richer has shown in his book on the 'Demoniacs in Art,' the religious art of the middle ages teems with pictures of cases of hysterical paralysis, convulsions, contractures, &c. In every case of cure at shrines, or by the exorcisms by saintly persons, the devil is represented as rushing out of the mouth of the sufferer. These pictures are many of them wonderfully accurate drawings of forms of disease that may now be seen at the Salpêtrière, or, in fact, at times at any general hospital. One must also add that cures were performed, and are even now performed at shrines, such as Lourdes, which we at our hospitals cannot rival.

The anæsthetic patches which appear in some hysterical cases used to be considered of great importance in the investigation of witches. They were called the "*Stigmata diaboli*." The magistrates, having demonstrated the fact that a sharp instrument might be thrust into such a patch without being felt, and even without the flowing of blood, accused the witch of having been in contact with the devil, and transportation to the witches' "Sabbath." Dr. Clarke* remarks that the ancient mode of investigation of the magistrates has its counterpart in that of the physician of to-day, who searches for the "hysterical stigmata," which mark the patient as suffering from "hysterical possession." He also draws attention to the remarkable fact that with the belief in witchcraft disappeared the knowledge of these anæsthetic patches, till 1843, when Piorry first made observation on them, to be followed by Briquet in 1850.

The manifestations of hysteria, or "stigmata," are almost endless in their number and variety. The literature on the subject is very extensive, and the proverb "*quot homines, tot sententia*" applies strongly to this study. I cannot possibly hope to deal exhaustively with the subject, but I hope to indicate the most important points in diagnosis of the most common types, to discuss the probable psychopathology, and lastly to suggest the lines which treatment should take.

Disorders of Movement.—The first, and a most important group, is that of the functional paralyses. They are important, because their similarity to organic paralysis is so close that they may easily be mistaken for such. The difficulty of diagnosis is all the greater because the patient frequently shows no other confirmatory symptom of hysteria, and is frequently a person the reverse of what might be called hysterical or emotional.

The loss of power may, according to the limbs affected, be paralytic in type, hemiplegic, or monoplegic, or it may affect single muscles, as in the case of hysterical aphonia.

Of these forms the paralytic type is perhaps the most common and the most liable to persist. There is, at the present time, a case of functional paraplegia in a woman at Queen Square, who for eighteen years has kept her bed on account of it. She shows no evidence of organic disease whatever. Could such a patient be brought under the influence of some healing shrine, her cure would strongly confirm the belief in miracles, and she is just the sort of case that might be permanently healed by such means.

In the diagnosis of functional paralysis, of whatever type, we are mainly guided by certain negative features. There is paralysis a positive feature, but often nothing else. Thus, there is generally no rigidity of muscle, but complete flaccidity; the reflexes are usually unaltered, except that frequently the sole reflex is much diminished—a symptom of considerable importance when present, as Buzzard has shown. There is often a complete absence of other hysterical symptoms, but when anæsthesia of the types (to be presently described) or analgesia, are present, the diagnosis is of course made more easy. There is never any bladder trouble, nor any tendency to bedsores, and wasting of the muscles affected is a very rare occurrence, though it has been observed apparently in Paris by Babinski. General wasting and malnutrition, however, is not uncommon as a cause rather than effect of the paralysis.

Functional paraplegia may come on in what appears to be perfect health without known cause. In such cases a most cautious prognosis must be made, for it cannot be too strongly insisted that serious organic diseases, such as disseminated sclerosis, are frequently preceded by years of functional manifestations, which have even been repeatedly apparently cured (Buzzard). But there is more often some definite cause—as fright with shock—or some antecedent ill-

* *Traité Clinique et Thérapeutique de l'Hystérie*, Paris, 1891. For this and many other references I am indebted to the admirable critical digest on the subject by Dr. Mitchell Clarke (*Brain*, vol. xv, p. 522, and vol. xvi, p. 119).

* *Brain*, vol. xv, p. 548.

health—most often anæmia—or some acute disease. The prognosis and treatment is much more hopeful in such cases.

Another definite type of paralysis is that of hemiplegia. Here, again, the resemblance to the organic form is very remarkable, and in the absence of distinguishing hysterical accompaniments, it may be almost impossible to diagnose it with certainty from that caused by cerebral hæmorrhage, especially in the early stages. But the functional type is generally associated with certain sensory disorders, which lead one to a correct diagnosis. Among these are hemianæsthesia and contractions of the fields of vision. The loss of sensation is generally much more complete than is even the case in organic diseases.

The following is, I think, a typical case of functional hemiplegia:

A. E. W.—, a boy, æt. 16, came as an out-patient to the National Hospital, Queen Square, on April 8th, 1891, with the following history:—Six weeks ago he was struck on the left occipito-parietal region, not severely, and there were no ill effects at the time. The next day, on trying to use the hammer, he found that his right hand was weaker than the left, and that there was at the same time some numbness. That evening he was feeling very unwell, and vomited. The day after that, at 10 a.m., he had a "screaming fit," in which he struggled very much, and required two people to hold him down. It lasted half an hour, and he did not bite his tongue nor pass his water involuntarily—in fact, a hysterical attack. Then he lay "quite unconscious" for a week, in the course of which he had suppression of urine for seventeen hours, and for two days his teeth were tightly clenched (hysterical trismus). He did not at any time suffer from involuntary micturition.

When his consciousness returned, he was found to be paralysed down the right side, face as well as limbs. For a week after he could not speak properly—says he could not finish his words. For a fortnight after he could not bite his food properly on the right side of the mouth; the food collected this side and fluids dribbled out. There was complete loss of taste on the right side of the tongue. At first he could not protrude the tongue at all, but later it deviated to the left.

Till fourteen days before appearing at the hospital he was quite paralysed on the right side, with complete loss of sensation but with no ascertained affection of sight. The leg recovered first.

When examined there was discovered no affection of vision, no contraction of visual fields, and no loss of taste. The mouth was drawn distinctly to the left on smiling, but tongue protruded straight. The right grasp was 20 k. of the dynamometer, the left 40 k. There was some want of co-ordination in movement of the right hand, so that the attempt to write resulted in a number of disorderly scratches. Tactile sensation only was somewhat dulled. His gait was natural, and the knee-jerks were feeble but equal.

He made an uninterrupted recovery, but was still anæsthetic slightly in the right hand ten months after, though that ultimately disappeared, and he ceased to attend.

He had suffered from hysteroid convulsions for many years—according to mother's account, from infancy; and his mother had suffered from hysteroid fits.

The monoplegic type of paralysis scarcely needs special mention. Any limb may be singly paralysed, but the features of the paralysis are the same as those described above. It is worth mentioning, however, that in cases in which the paralysis follows a distinct blow on the head, and is accompanied by fits, one may be deceived into thinking that there is an organic lesion of the brain. I have seen several of such cases, and in one I was able to demonstrate the purely functional nature of the paralysis and convulsions, and so prevent an operation which would have been useless and probably prejudicial.

A functional paralysis, be it of single muscles or limbs, stripped of all accessories and reduced, so to speak, to its simplest terms, stands before us as a simple temporary loss of voluntary power of movement. In other words, the influence of the will in calling forth muscular action is in abeyance. Sir James Paget,* in one of his most apt and comprehensive sentences, describes the state of affairs thus: "She says, when asked to perform some movement of the paralysed limb, as all such patients do, 'I cannot;' it looks like, 'I will not;' but it is, 'I cannot will.'"

(To be continued.)

From the "Directory" we learn that over 2200 Bart.'s men are in practice in England and Wales.

* Paget, *Clinical Lectures*, 1879, p. 188.

Clinical Lecture.

By THOMAS SMITH, F.R.C.S., January 23rd, 1895.
(Abstract by S. R. DOUGLAS.)



HE first case I have to bring before you is a simple one, namely, tuberculous abscess of the neck.

A good-looking woman, æt. 36, was admitted on December 28th, 1894.

History.—Eight months ago, after an ulcerated sore throat, she noticed a lump in her neck, about the size of a pea, which gradually grew larger; for the last six weeks it has remained about the same size. There is no family history of tubercle.

Present condition.—There is a swelling about the size of a walnut situated on the left side of the neck in front of the sterno-mastoid, which is tense, fluctuating, and not adherent to the skin.

On January 2nd an incision about three quarters of an inch long was made into the swelling, and a quantity of yellowish-green pus let out; the cavity was then scraped with a sharp spoon, removing some flaky pus, and washed out with perchloride of mercury 1 in 4000. A drainage-tube was put in and the wound was sewn up with fine catgut. The wound was dressed daily till January 10th, when patient was discharged, the wound being then nearly healed, but a small quantity of discharge was still present.

The points to be noticed about this case are—

(1) That the woman was perfectly healthy, and yet she had a tuberculous abscess, the bacillus having most likely gained access through her tonsil when she had the sore throat. The bacillus here was sown on an unsuitable soil, and the affection of the one lymphatic gland shows that one use of these glands is to eliminate from the body, by means of suppuration, certain substances which are injurious to it.

(2) The treatment by incision, scraping, and drainage was to prevent undue scarring, the scar resulting from this procedure being smaller than if the gland had been dissected out.

I will now make a few remarks in general about tubercular glands in the neck. After the discovery of the true nature of tubercle, surgeons began to try and extirpate it locally.

Dr. Clifford Allbutt and Mr. Teale published a series of lectures in the *Medical Times and Gazette* of 1885.

In these lectures Mr. Teale advised surgical interference for the treatment of these glands in the neck under the following circumstances:

- (i) When a sinus resulted.
- (ii) When pus was present in a lymphatic gland.
- (iii) When the enlarged glands were known to be tuberculous.
- (iv) When the glands were chronic and an eyesore, whether they were tuberculous or not.

In sixteen cases which were operated on, half of them had a duration of more than two years, and not one had existed for less than two years, showing that Mr. Teale did not approve of surgical interference in the early stages of the disease.

At the present time some surgeons advise removal at a very early stage, the plea of justification of this measure being that the tubercle may become generalised. This is quite true as a pathological fact, but is rather alarming, and as a statement ought not to be made to the friends of patients, as it gives to them an exaggerated idea of the gravity of the case: besides—

First, all enlarged glands are not tuberculous.

Secondly, supposing the gland is tuberculous, it may disappear under appropriate treatment.

Thirdly, general infection is very rare, as is shown by the countless numbers of people going about with the scars of tubercular abscesses in their necks.

Fourthly, in the early stages fresh glands are continually becoming enlarged in some cases, and it would be impossible to remove all the glands without frequently repeated operations.

Fifthly, even if the glands suppurate the resulting scar is not so disfiguring as the scar of an operation when the incision is more than two inches long.

The most suitable cases for removal are—

- (i) Where the glands are very chronic.
- (ii) Where no fresh glands have appeared for some time.
- (iii) Where the glands are indolent.
- (iv) Where there is a sinus.

A suppurating gland is best treated by an incision into it, thorough scraping, washing out with perchloride of mercury, and drainage; where there is much solid substance, it had better be removed.

The general treatment required to see if the glands will disappear without operation is, in the first place, fresh air, preferably sea air.

As regards medicines, cod liver oil and some preparation of iron, to which is added some potassium iodide; this is better than the syrup of iodide of iron.

In the way of local applications, it is no good painting iodine on the skin, as the lymphatics of the skin do not pass to these glands; the best way is, if it is thought desirable to use iodine locally, to paint the tonsils, or if the glands are situated anteriorly, the floor of the mouth, with a mixture of glycerine and iodine; in this way the iodine is carried direct to the glands.

I do not mean to imply by these remarks that I disapprove of the removal of tuberculous glands, but I do disapprove of their removal in the early stages of the disease, and before constitutional treatment has been fairly tried.

The next case is one of suppuration round the appendix vermiformis.

A man *æt.* 34 was admitted on December 19th, 1894. Thirteen days ago he had pain in his belly. Eleven days ago vomited frequently, temperature raised. For the last week he has had pain in the belly, especially in the right iliac fossa, and the temperature, which had fallen, has been raised for the last few days. Bowels have been constipated during the illness.

Present condition.—The abdomen is not distended, and is soft except in right iliac fossa, where a hard, tender, ill-defined mass is found extending upwards into lumbar region. The patient was put under chloroform, and an incision about three inches long was made just above and parallel to Poupart's ligament. The muscles were divided, and on puncturing the fascia transversalis a large quantity of fetid pus escaped. The abscess cavity extended about six inches upwards towards the lumbar region, and downwards for about three inches towards the groin. Two drainage-tubes were inserted, a longer one passing upwards and a shorter one downwards; the cavity was washed thoroughly with perchloride solution $\frac{1}{1000}$. Temperature fell shortly after operation, and beyond the constipation, which was troublesome to overcome, the patient has done exceedingly well.

The chief points about this case to be noticed are—

(i) He had been ill for thirteen days without general peritonitis—a favourable sign, showing that the general peritoneal cavity was not affected, and that probably firm adhesions existed.

(ii) When an abscess spreads upwards towards a lumbar region, it is generally a bad sign, the pus tending to become diffused amongst the cellular tissue, and produce extensive phlegmonous abscesses.

I have been in the habit of making the incision for opening appendix abscesses below level of peritoneum, and then working round to get below the swelling. If no pus is found I explore the peritoneum with a needle, opening it if pus is found from below, this being a safer method than cutting straight down on to the swelling,—that is, being less likely to break down any adhesions and let the pus enter the general peritoneal cavity. If no pus is found with the needle I put a large drainage-tube to the bottom of the wound, and thus make an easy way for its escape.

It is not as a rule necessary or wise to make a prolonged search for the appendix, which has very often sloughed, but if it is found, or concretions are felt, it ought to be removed. It is not in my experience that an appendix, once perforated or ruptured, gives any further trouble when the matter has been let out.

Clinical Lecture on a Case of Hemianæsthesia.

By SAMUEL GEE, M.D.

February 15th, 1895.

DR. GEE began by saying that his lecture would be on Hemianæsthesia, especially in relation to a patient in Luke Ward, a man *æt.* 28. He, three months ago, noticed numbness in his left leg; this numbness is often a subjective symptom, but in this case was probably real anæsthesia: he described "pins and needles" and pain in the left calf. The numbness has since spread, so that it now involves the whole of the left side of the body. Two months ago clonus developed so as to affect gradually the whole of the left side of the body. The legs became weaker, so that for five weeks before admission he was unable to do any work. He also noticed dimness of vision in the left eye. In this patient consider—

1. The anæsthesia.

2. The affection of mobility.

The patient denies syphilis, and there are no symptoms of cerebral tumour or brain trouble.

1. *The anæsthesia.*—It is not complete, inasmuch as there is a

dull feeling on pressure. The anæsthesia is limited to the left side of the body, to the sensations of touch, pain, heat, and cold. The mucous membranes seem to have escaped.

Pupils.—Actions natural.

Smell.—Is defective on the left side, as tested with musk and ammonia.

Sight.—On the left side vision is dim, as he says, and there is found to be, by the perimeter, contraction of the field of vision, to which the dim sight is therefore due. Vision, as tested by types in the contracted field, is perfect.

Hearing.—Cannot be properly tested, as he has old disease of the right ear.

Taste.—Is slightly impaired on the left side of the tongue.

2. *Motor symptoms.*—Rigidity and clonus on the left side. The facial muscles on the left side are slightly weakened. The tendon-reflexes on the left side are increased, as shown in those of the arm, supinator, triceps, &c., and leg, patellar tendon-reflex on the left side being as great as it can be. Spastic rigidity has not been observed in the left arm whilst in hospital, although he says he has noticed it, but it is very marked in the left leg. *Spastic hemiplegia.* On walking he stiffens his left leg and swings it round. In addition he has clonus on the left side, especially in the left leg; and he says that his left arm and the left side of his face have been so affected. There is no muscular atrophy, and reaction to the faradic current is natural. Micturition is natural. *What is the nature of his complaint?* Hemianæsthesia is the most characteristic symptom. It is usually a *functional disease*—or, as it may be called, hysterical. An objection to the word hysterical might be made because of his sex, being a man aged twenty-eight. But, on looking over my notes of cases in the hospital, it is remarkable what a number of males have been hysterical, especially boys and youths. Besides the hemianæsthesia there is another affection—the motor symptoms—spastic rigidity. This also may certainly be functional or hysterical, and there is no other evidence of anatomical or structural disease, such as tumour, arterial obstruction, or hæmorrhage. The two latter would come on suddenly, unlike this case. So that the complaint is purely functional.

To further illustrate the case, take another one, that of a young woman *æt.* 20, who was in Mary Ward. The case is reported by Mr. Jessop in the *Hospital Reports* for 1880. She suffered from *hystero-epilepsy*. The left side was affected as in the man, it is generally more often affected than the right. As to her sensibility, *sight* on the left side was such that she could only distinguish light from dark. *Hearing* was not so good, and taste was impaired on the left side. Common sensibility was affected on the left side. She could only move her arm imperfectly. There was no wasting of muscles—no spastic rigidity. The patellar tendon-reflex was present on both sides. The anæsthesia spread later, and later still rigidity developed in the left arm and leg. The anæsthesia was confined exactly to the left side. Ankle-clonus developed later in the left foot; so by this time she had become much like the first patient noticed.

One day, after having been discharged from the hospital some time, she had a hystero-epileptic fit; and from this time she became better, losing the rigidity and the anæsthesia.

This patient became the subject of a severe attack of chorea, affecting both sides of the body.

The contraction of the field of vision in her on admission was very small, but it became worse, even to blindness, in the left eye. The amaurosis was nearly complete. A year later white atrophy of the disc of that eye set in, although the other symptoms had cleared up, viz. the anæsthesia and rigidity. Both these cases illustrate functional hemianæsthesia.

The third case shows a non-functional condition. He was a man aged forty-four; he was in the hospital a few years ago.

As regards the hemianæsthesia, the sense of touch was impaired down the right side. There was no deafness. No amblyopia, but he suffered from hemiopia, blind in half the field of vision of both eyes. He used to play the violin, and the first thing he noticed was a deficiency in reading his music, and later he found he could not see things on the right side,—in fact, at dinner one day, not being able to see on the right side, and with his defective touch, he tried to raise food from his plate with his knife, the blade of his knife being all the time under his plate, and not upon it. The perimeter showed complete loss of sight on the right side of the field of vision.

The man died in the hospital shortly after his admission, and a tumour was found in the occipital lobe, just beneath the second occipital convolution. It was almost the size of a walnut. Hemiopia is never a functional disease, excepting when it is very temporary, lasting, say, thirty minutes, as in megrim, but otherwise shows disease of the lobes or the nerves. The hemianæsthesia in this case was explained by the compression of the hindmost and lowermost part

of the posterior limb of the internal capsule. (See report of case in the *Hospital Reports*, vol. xxvi, for 1890.)

P.S.—With regard to the patient in Luke, aged twenty-eight, with the hemianæsthesia, he discharged himself on February 26th. At that time the hemianæsthesia had quite disappeared, his gait was almost natural, and the tremors had almost entirely disappeared; the reflexes were unaltered. His taste and smell were natural, but his field of vision was still very contracted.

A Visit to a Norwegian Leper Hospital.

By E. MANSEL SYMPSON, M.D., B.C.Cantab., M.R.C.S.,
Surgeon to the County Hospital, Lincoln.

FEW pleasanter places greet the traveller's eyes in Norway than the little town of Molde; like Horace's well-beloved Tibur, "Ille terrarum mihi præter omnes angulus ridet." The long street straggles by the water's edge. The houses, clean as ever in Norway, are gay with roses, while behind the town the land, well wooded, gently rises to the bases of the mountain range beyond. Southwards it looks over the Molde Fjord, studded with islands, to the snow-clad Romsdal Alps, where the huge bastion of the Romsdalshorn guards the entrance to the valley, and seems to frown defiance at its opposite neighbours, the Trolltinderne (Peaks of the Trolls, or giant mountain goblins), as they rise for some 7000 feet, like the ribs of some wrecked ship from the sand, or like a mighty wave on the verge of breaking, as it tosses upwards its jagged and shattered crest into the sky. Except a fine altar painting in the church, and the usual attractive shops, full of silver mugs, spoons, &c. (what a vast number of tiny chalices are on sale!), wood-carving from models of carioles to gigantic beer-jugs (if you wish to see a superb collection of beer-jugs and mugs visit the Bergen Museum), there is not much of great interest in Molde till you reach my more immediate subject, the Leper Hospital. This is situated a little west of the town, and is a spacious well-built place, of course of wood. It is more than ordinarily spick-and-span without and within with paint; and I noticed that the floors also were painted—a cleanly practice, as it suffers no cracks or fissures wherein the wily germ may lurk, to "come up smiling" when the hour is come, and the man (or woman). The hospital can hold, I believe, some fifty or more, and perhaps I may have seen twenty patients therein. An old Bart.'s man, Dr. Lightbody, now of Nantwich, an enthusiastic mountaineer, accompanied me in my visit to the hospital, where we were most kindly treated by the courteous superintendent. Several—I think more than half the cases we saw were of the anæsthetic kind, chiefly in elderly people who had lost one or more joints of the fingers. In some there was well-marked Dupuytren's contraction of the palmar fascia; in others the glossy skin, overgrowth of nails, and the anæsthesia characteristic of neuritis. Not a few had the joints of the fingers swollen, and the appearance of their hands suggested very strongly osteo-arthritis—an interesting point for those who, like myself, believe in Dr. Garrod's opinion that osteo-arthritis is a disease of nervous origin. It was quite surprising in one ward we visited to see how deft and clever the old ladies were in spinning, though with anæsthetic and mutilated fingers.

The tubercular cases were naturally far the saddest, for some of these were young. The eyes were almost always affected, and that early, tubercles appearing on the corneal conjunctiva and on the inside of the eyelids. One case, where a large part of the face was eaten away by the disease, strongly resembled lupus. In another, while there was much ulceration of the hands, there seemed to be no tubercular process going on at all. In this tubercular kind there were, as far as I was able to make out, no affections of the joints.

Happily, even in Norway this complaint is dying out, and it is on the cards that this very hospital at Molde may soon be shut up for lack of patients. The captain of the steamship "Venus" (who safely carried us through the most devious waterways that can be imagined, but whose *deportment* might reasonably have been [and was] grumbled at between Newcastle and Bergen) told me that the cases arose almost entirely among fishermen and their families, and ascribed it to the poor and bad diet on which they live, consisting as it does of fish. It is interesting in this connection to see in the account-books in England, when we had lazaret (leper-) houses scattered thickly over the face of the country, how large a part is taken up with the sums paid for dried "stockfish," an article speedily known, at least by odour, to the visitor to Bergen as he walks into the town past the old Hanseatic

warehouses. Humanity generally, and especially in Europe, may be congratulated on the departure of leprosy from our midst, and we may feel confident that, with better food and better sanitation than of old, the foe now beaten back will never molest us again.

Case of Angina Pectoris, with Post-mortem, showing almost complete obstruction of the left Coronary Artery.

By WILLIAM WYLLYS, L.R.C.P., M.R.C.S., L.S.A.,
Great Yarmouth.



S—, male, æt. 64 years, seaman, had never suffered from any cardiac symptoms till commencement of 1894, when he began to complain of shortness of breath on exertion. He continued work, however, until beginning of December last, when, one evening, after partaking of a substantial meal, he was suddenly seized with pain and great oppression in mid-sternal region, causing him to start up and seize the mantelpiece, in which position he stood some minutes gasping for breath, with an expression of agony upon his face, which first turned white and then livid. After subsidence of the attack the patient still remained standing, apparently in dread of a repetition of his sufferings.

In describing his sensations, he said that the oppression in his chest felt like a huge weight pressed on his heart and lower end of chest-bone, and that with it he also had pain in the upper part of his back, which ran down the back of left arm and hand to the very tips of his fingers; he felt very cold, and "as though he must die." He attributed the attack to indigestion, for the eructation of wind relieved his suffering, and after taking some brandy he felt better.

The patient was a man of middle height, short-necked, rather fat, but muscular; he carried his head bent forward between his shoulders, which were markedly elevated and rounded. He possessed only the stump of a tongue, the anterior half having been removed for cancer twelve years ago at Guy's Hospital, with no return of the disease whatever; his few remaining teeth were mere decayed stumps; his pulse (between the attacks) was irregular in frequency and force, of poor tension and volume, but not accelerated.

Chest, barrel-shaped, giving a boxy note on percussion; breath sounds feeble; expiration prolonged, heart dulness markedly diminished; heart sounds muffled, the first, over lower part of pre-cordial area, being hollow; apex beat not felt.

Bowels, subject to constipation.

Urine, after attacks contained thick pink deposit of urates.

Past Illnesses.—Cancer of tongue as stated; never rheumatism nor gout; no history or signs of syphilis; had been a heavy drinker (beer and spirits) till seven years ago, when he became a teetotaler; big meat eater; liable to attacks of indigestion; had strained his back several times in lifting heavy weights.

Family History.—Married man, no family; wife living, no miscarriages; his mother died of consumption, and father at 44; cause unknown.

Treatment.—Patient was advised to avoid bodily exertion and mental excitement; not to go out when cold winds were blowing, and never to overload his stomach. His bowels were regulated, and as no aortic regurgitant murmur could be detected, the following mixture was prescribed:

℞ Tinct. Digitalis, ℥xl;
Ammon. Carb., grs. xxxij;
Ætheris, ʒj;
Sodæ Bicarb., ʒij;
Aq., ad ʒvii.

ʒj ter die sumend.

Also five drops of amyl nitrite to be sprinkled on a handkerchief and inhaled when attacks appeared to be coming on. The precautions as regards handkerchief were quite useless, however, for in a short time patient became so fond of his amyl, that he would sit and sniff at the bottle containing it to his heart's content whenever he felt at all indisposed.

The mixture was subsequently replaced by Tabloids of Nitro-glycerine $\frac{1}{100}$ gr., one twice a day. Patient expressed himself as feeling better for the treatment, and at beginning of February came to see me, to know if he might return to work, although in January he had four attacks (one very severe), and this month several more, I

instructed him to go home and remain indoors while the very cold weather continued; however, on the evening of February 16th, the wind blowing sharply from the east, he walked out to see his employer, being very anxious about his work, and on his way home fell down dead.

Post-mortem (twenty-four hours after death).—Well-marked rigor mortis; veins of neck distended. *Tongue*, remaining portion showed no signs of any recurrence of epithelioma. *Lungs*, emphysematous; marked pouching of anterior margins. *Pleura*, normal. *Pericardium* contained two ounces of clear colourless fluid; no adhesions. *Heart*, much enlarged, flabby, and of pale brown colour, covered in places with a considerable amount of fat; weight, twenty-two ounces; right side distended with blood. *Right auricle* dilated; thin friable walls. *Right posterior tricuspid valve* showed two small fatty opaque patches. *Right ventricle* slightly dilated; pale-coloured friable walls. *Left auricle* much dilated, walls very thin and soft. *Mitral valves*, three patches of atheroma. *Left ventricle* in its upper two thirds was of natural colour and strong, but in lower third was very thin and friable, being slightly pouched and consisting of but one-sixteenth of an inch of muscle and one-eighth of an inch of fat; it held seven ounces of water. *Pulmonary*, aortic, mitral, and tricuspid orifices of normal calibre. *Aorta* showed numerous patches of fatty degeneration. Aortic valves not diseased. Openings of both coronary arteries constricted by atheromatous material. *Right coronary artery* dilated, its walls for three inches containing masses of calcareous deposit. *Left coronary artery* of similar character to right, but about three inches from origin so infiltrated with calcareous matter as to admit only the point of a pin. *Liver* enlarged and hard. *Spleen* enlarged and hard. *Kidneys*, capsules slightly adherent: cortices thinned. *Left kidney*, two small cysts on surface. *Brain* not examined. The exciting cause of death in this case no doubt was the effect of a cold east wind combined with mental excitement.

Remarks.—This case is, I think, of interest in showing that a number of severe paroxysms of angina pectoris occurring within a short period of time can be survived by a patient of advanced years, with serious heart disease—in proving angina to be a disease manifested by *symptoms* rather than by *signs*, and chiefly in bringing out the marked relation of the degenerative changes in the heart-substance to the calcification of the coronary arteries, the area of heart-wall supplied by the *left* coronary artery beyond its obstruction being, in this instance, far more degenerate than any other part of the organ.

Notes.

SIR DYCE DUCKWORTH gave the monthly lecture to the Royal British Nurses' Association, choosing for his subject "The Modern Trained Nurse." In the course of his address he did not shirk the unpleasant question of the relation of nurses to medical men, and spoke very plainly on the tendency of the "highly trained nurse" to pass out of her proper sphere, and to take up responsibilities which do not belong to her. The nurse's business is, he said (and he spoke with emphasis), when placed in charge of a case, to carry out the doctor's orders with implicit obedience and exactitude; if she has any *opinions*, she should keep them to herself, and not discuss medical matters either with the doctor or the patient's friends.

SIR DYCE DUCKWORTH has evidently no sympathy with women's franchise, for in the course of his lecture he said he regarded matrimony as the "highest outcome" of women's life.

DR. CHAMPNEYS, as President of the Obstetrical Society of London, delivered his inaugural address to the Society on March 6th, dealing with the subject of midwives, and their relations to the public and to the medical profession.

MR. THOMAS SMITH, our senior surgeon, has been appointed by the Queen to be one of Her Majesty's Surgeons Extraordinary. We congratulate him most heartily upon this recognition of his eminent and leading work as a surgeon.

MESSRS. MACMILLAN AND Co. have just published "A Course of Elementary Practical Bacteriology, including Bacteriological Analysis and Chemistry," by Dr. Kanthack and Dr. Drysdale. It is founded upon the slips and notes which the authors have been hitherto accustomed to give out to those taking the Bacteriology Class in our Laboratory. A review of this book will appear in our next issue.

A NEW EDITION of *Walsham's Surgery* has just appeared.

WE WERE GLAD to see so many of the staff at the "Smoker" which was held in the Library on March 22nd. Amongst those present were Mr. Thomas Smith, Mr. Marsh, Mr. Walsham, Dr. West, Dr. Griffith, Mr. Bowlby, as well as Dr. Calvert, Dr. Fletcher, Dr. Garrod, Mr. Bailey, Dr. Bowman, and Dr. Hayward. Some years have now elapsed since the last smoking concert was held in the Library, and the "rowdiness" which then occurred put a stop to them at that time. It made it also very difficult to obtain permission from the authorities to hold the present one. We are very pleased, however, to note that the proceedings were on the present occasion most orderly, and now that these enjoyable evenings in the Library have been resumed without detriment to the patients, whose welfare must obviously be the first consideration with the hospital authorities and the staff, we hope that nothing will occur in the future to stop them.

A NOTICE has been posted on the Abernethian notice board asking those members who wish to be present at the *Conversazione* on May 1st to give in their names to Mr. Madden, the Librarian, and to intimate at the same time whether they desire also to receive a ticket for one friend. We have been asked to say that those members of the Society who have not yet done so should lose no time in applying if they desire to be present, for admission will be solely by ticket.

WE HAVE been asked also to repeat the announcement made last month to *past members* of the Society, that those who desire to be present on May 1st should communicate with the Secretaries of the Abernethian Society at once. In their communication they should state whether they wish for a ticket for a friend. To all who make application, tickets of admission will be sent in due course. April 22nd has been fixed as the date before which all applications for tickets must be sent in. Those members who wish to bring more than one friend should state the fact; their applications will be considered in order of priority, and any spare tickets will be distributed accordingly.

WE HEAR that the arrangements for the *Conversazione* are fast approaching completion, and that no pains or expense will be spared to make the occasion a genuine success, and in every way worthy of the Centenary of the Society and of the Hospital. Three members of the School Committee, as well as Mr. Cross, the Clerk of the Hospital, are co-operating with the Abernethian Committee in carrying out the arrangements.

A PROGRAMME, which, however, is subject to alterations, has been issued, and runs as follows:

Great Hall.—Refreshments and Dan Godfrey's Band during the whole evening.

Library.—Exhibition of Pictures, and Entertainments by Dramatic and Musical Societies.

Anatomical Theatre.—Lecture, "History of the Abernethian Society," by Dr. Norman Moore, at 9 p.m.

Medical Theatre.—Demonstration, with limelight, by Dr. Kanthack, at 10 p.m.

Physiological and Pathological Laboratories.—Instruments, Apparatus, and Experiments by Drs. Klein, Edkins, Fletcher, and Cautley.

Museum.—Open.

Dissecting-room.—Band; Exhibition of Instruments by Messrs. Arnold, Down, Maw, Son, and Thompson, Ferguson, Baker, and Hicks, and display by the St. John's Ambulance.

Abernethian Room.—Exhibition of Photographs by the Photographic Society.

AN APPLICATION has been received by the Finance Committee of the Amalgamated Clubs from the Shooting Club to be admitted into the Amalgamation.

WE DESIRE to draw attention to the decision of the Finance Committee in regard to the Club colours printed in another column.

AT A SPECIAL General Meeting of the Abernethian Society held last month, a proposal to modify the Rules of Society so that any subject may be debated at a meeting, and that papers should not necessarily be confined to medical topics, was discussed, and negatived. It was thought best that if opportunity for debating general topics is desired, a separate Debating Society should be founded.

WE WISH to draw special attention to the notice in another column, inviting those old Bart.'s men who are willing to play for "past" students in the cricket match on the occasion of the formal opening of the ground on June 8th, to communicate with the Secretary of the Cricket Club, so that a team may be selected.

WE ARE GLAD to see the announcement which Dr. Kanthack has made that he intends to hold some classes in Pathological Chemistry for his clerks and for M.B. men during the Summer Session.

WE ARE GLAD to see that the Medical School authorities have just issued a "Directory of medical men educated at St. Bartholomew's Hospital in practice in England and Wales." It is a closely printed pamphlet of thirty-four pages, and the names are classified under the addresses. It will,

we doubt not, prove to be very useful in looking up what "Bart.'s men" reside in particular towns.

IT IS HOPED that the Rahere Lodge No. 2546 will be consecrated shortly after the return of the Pro Grand Master, the Earl of Lathom, from the West Indies. All communications in reference to the Lodge should be made to the Secretary, Mr. T. G. A. Burns, of 25, Welbeck Street, W., or to the treasurer-designate, Mr. D'Arcy Power, at St. Bartholomew's Hospital.

DR. J. CALVERT has been reappointed Demonstrator of Materia Medica and Pharmacy, and will give a course of demonstrations on Wednesdays at 9 a.m. during the summer session, similar to the course which he gave last year. In association with these demonstrations there will, as usual, be held a practical class in pharmacy in preparation for the examination in this subject in July.

DR. H. M. BOWMAN has been re-elected Assistant Demonstrator of Materia Medica and Pharmacy.

MR. C. P. WHITE, whose term of office as "The Treasurer's Research Student" has expired, will, we hear, shortly publish some of the results of his researches.

MR. J. W. W. STEPHENS, who has for some months been engaged in research work in conjunction with Dr. Kanthack, has been nominated to the Treasurer's Research Studentship for a year from April 1st.

THE HARVEY PRIZE has been awarded to Howell Davies; and E. C. Morland, who is *proxime accessit*, has been granted a certificate of honour.

"THE JUNIOR PRACTICAL" has been carried off by F. C. Borrow, and the following have been awarded certificates of merit, having obtained the next nine places in order, viz.:—Leonard and S. R. Scott (*æq.*), H. Burrows, A. R. Baker, C. S. Frost, H. S. Thomas, E. Wethered, C. R. Brown, and L. A. Walker.

"THE SENIOR PRACTICAL" has been gained by R. Raines, and the following nine have been adjudged worthy of a certificate of honour, in order of merit, viz.: E. C. Morland, L. A. Baiss, and G. E. Gask (*æq.*), A. O. B. Wroughton, W. T. Rowe, S. A. Millen, H. E. Waller, H. D. Everington, and F. Horridge.

W. J. GILLESPIE has passed the Final L.S.A. in Medicine, Forensic Medicine, and Midwifery.

WE ARE SORRY that the Examiners did not consider any of the candidates for the Kirkes' Scholarship and Gold Medal worthy of the prize. It is only very seldom that a scholarship is not awarded.

WE congratulate Dr. Kanthack on his marriage to Miss Henstock, sister of an old Bart.'s man, which took place in Liverpool on April 17th.

* * *

THE Eighth Decennial Club has been formed, and will hold its first dinner in July next. It is composed of men who entered at Bart.'s between the years 1885 and 1895 inclusive, and have since become qualified. The annual subscription is 2s. 6d., and the secretaries are Dr. Kanthack and Mr. Waring.

* * *

THE Jacksonian Prize of the Royal College of Surgeons has been awarded to Mr. H. J. Waring for an essay on "The Diagnosis and Surgical Treatment of Diseases of the Liver, Gall-bladder, and Biliary Ducts." We congratulate Mr. Waring heartily.

Amalgamated Clubs.

NEW MEMBERS.

J. Young. F. W. Gale. E. C. Hepper.

FINANCE COMMITTEE.

THE following have been unanimously adopted as the Colours of the Amalgamated Clubs:

(1) There are two blazers: (a) a general blazer, which any member of the Amalgamated Clubs may wear; (b) a special blazer, to be worn only by those who have represented the Hospital in some Inter-Hospital Cup competition.

(2) The general blazer is plain black, with brass buttons, and with the Hospital shield worked in black and white silk on the pocket.

(3) The special blazer is to have broad black and narrow white vertical stripes (black 3 inches wide, white $\frac{3}{16}$ inch wide), with silver buttons, and with the Hospital shield worked on the pocket as in the general blazer.

(4) A sash may be worn by any member of the Amalgamation, and is to be of the same pattern as the special blazer.

(5) There are two kinds of caps: (a) General, which may be worn by any member, of plain black with hospital shield worked in silk over the centre of the peak; (b) special, to be worn with the special blazer, and of the same material as the special blazer, and without the shield.

(6) The hat ribbon is to be of diagonal black and white stripes (black $2\frac{1}{2}$ inches wide, white $\frac{3}{8}$ inch wide).

(7) The tie is to be of black and white stripes; black $1\frac{3}{4}$ inches wide, white $\frac{1}{8}$ inch wide.

(8) The bow tie is to be $1\frac{1}{4}$ inches wide, of black ground with three horizontal stripes in white, one in centre, and one at each edge, each $\frac{1}{16}$ inch wide.

(9) These articles can only be obtained from Mr. G. Lewin, 8, Crooked Lane, Cannon Street, E.C., upon an order from the Secretary of the Amalgamated Clubs.

The formal opening of the ground has been fixed for June 8th. A match between past and present Bart.'s men will be played, and all old Bart.'s men who are willing to play are requested to communicate at once with the Secretaries of the Cricket Club in order that a team may be selected.

ASSOCIATION FOOTBALL CLUB.

The football season for 1894-5 was brought to a very successful close by our winning the Inter-Hospital Cup on Monday, March 25th. Since the Hospital Cup has been started Guy's Hospital has held it five times, Bart.'s five times, and St. Thomas's once.

Altogether the season has been a most successful one for us, as we have won most of our matches, although the fixtures have been with teams stronger than in former years. We were rather unfortunate in being beaten by Ilford in the London Cup, a draw being the result of the first match with them, and in the replayed tie they just managed to get one goal ahead a few minutes before time. In the Hospital Cup we beat London Hospital, St. Thomas's, and Guy's, and scored twenty-one goals against one goal, which was scored by London.

We regret that next season we shall lose the valuable services of our captain, J. F. Fernie, and also E. H. Fryer, W. H. Pope, and C. C. Costin; still we hope that some new men will come up before the football season begins again, and that we shall have as good a team as we have had this year.

J. F. Fernie has been chosen in the Hospital Cup team for five successive seasons, and has been in the winning team three times. He also played regularly for United Hospitals, and has been chosen to play for London and Middlesex on several occasions.

Our record for the season is—

	Played.	Won.	Drawn.	Lost.	GOALS.	
					For.	Against.
First Eleven	25	14	5	6	78	47
Second Eleven	20	13	5	2	73	35

Saturday, March 2nd.—ST. BARTHOLOMEW'S HOSPITAL v. ST. ALBANS.

This was played at St. Albans before a good number of spectators, but neither club was fully represented owing to illness. At first St. Albans had matters a little in their own hands, but did not score, Fox saving splendidly on several occasions. After a little Bart.'s settled down and began to press, and after some struggles in front of goal Fernie scored the first goal for us. In the second half the play was a trifle rough, and numerous fouls were given. Bart.'s played up the slight incline, and had rather hard luck in not scoring several times. Waterhouse, after about a quarter of an hour, scored from a very hot shot, and shortly afterwards Fernie added another to our score. St. Albans made several hard attempts to score, but were unsuccessful, and the game ended in a win for Bart.'s by three goals to nil.

Team.—E. H. B. Fox, goal; R. P. Brown, L. E. Whitaker, backs; C. G. Watson, H. J. Pickering, A. Substitute, half-backs; T. H. Talbot, C. A. Robinson, right wing; J. F. Fernie, centre; R. Waterhouse, E. W. Woodbridge, left wing.

Saturday, March 16th.—ST. BARTHOLOMEW'S HOSPITAL v. EALING.

On this occasion we were very unfortunate in not being able to take a strong team down to Ealing, as the proceeds of the gate were distributed amongst local charities. The attendance was very large, but owing to our weak team and the rather rough ground those present did not witness a very good game. Fernie, Pickering, and Robinson were playing for London v. Army, and others could not play, so the team ended in being practically a reserve team. For the first quarter of an hour Bart.'s held their own, but after that fell to pieces, and were fairly outclassed, being beaten by five goals to nil.

Team.—E. H. B. Fox, goal; R. P. Brown, L. E. Whitaker, backs; C. G. Watson, J. C. Marshall, T. Dawson, half-backs; A. Hay, R. Waterhouse, right wing; C. H. Prance, centre; G. R. Fox, T. H. Talbot, left wing.

INTER-HOSPITAL CUP.

SEMI-FINAL TIE.

ST. BARTHOLOMEW'S HOSPITAL v. ST. THOMAS'S HOSPITAL.

This match was played on the Essex County ground at Leyton, before a fair attendance. From start to finish Bart.'s had matters all their own way, at half-time leading by six goals to nil. When time

was called we had added six more goals, and thus won easily by twelve goals to *nil*, which is a record in Hospital Cup ties. The goals were scored by J. A. Willett 6, J. F. Fernie 3, C. A. Robinson 2, A. Hay 1.

TEAMS.

St. Bart's.—E. H. B. Fox, goal; R. P. Brown, L. E. Whitaker, backs; W. H. Pickering, C. C. Costin, W. H. Pope, half-backs; A. Hay, C. A. Robinson, right wing; J. F. Fernie, centre; J. A. Willett, E. W. Woodbridge, left wing.

St. Thomas's.—W. Halstead, goal; T. H. Brown, H. C. Jonas, backs; E. Raven, T. Cowell, A. R. Jones, half-backs; F. Bawtree, J. B. Tombleson, right wing; E. A. Gates, centre; R. H. Allport, J. Jearsley, left wing.

Referee.—Mr. C. W. de Lyons Pike.

Linesmen.—Messrs. A. H. Harrison (*St. Thomas's*), H. Hailey (*Essex*).

FINAL TIE.

ST. BARTHOLOMEW'S HOSPITAL *v.* GUY'S HOSPITAL (Holders).

As usual, a good yelling crowd witnessed this match at Leyton. The ground was in perfect condition, but a very strong wind which was blowing rather spoilt the game. *Bart's* played against the wind during the first half, and had rather a hard task to keep their opponents from scoring on several occasions, but nothing was scored at half-time. On again resuming play *Bart's*, with the wind at their backs, pressed continuously, but could only score once from a difficult left-foot shot by Fernie, and thus *Bart's* won by one goal to *nil*. Mention should be made of the brilliant goal-keeping of E. H. B. Fox in the first half and the safe defence of L. E. Whitaker.

TEAMS.

St. Bart's.—E. H. B. Fox, goal; R. P. Brown, L. E. Whitaker, backs; W. H. Pope, C. C. Costin, H. J. Pickering, half-backs; A. Hay, C. A. Robinson, right wing; J. F. Fernie (Capt.), centre; J. A. Willett, E. W. Woodbridge, left wing.

Guy's.—N. Lavers, goal; N. B. Carter, W. R. Davis, backs; A. Crosby, F. E. Walker, R. H. J. Swann, half-backs; K. B. Alexander, W. G. Palmer, right wing; R. T. Fitzhugh (Capt.), centre; L. Humphrey, R. B. Stamford, left wing.

Referee.—Mr. C. W. de Lyons-Pike.

RUGBY FOOTBALL CLUB.

Friday, March 8th, 1895.—ST. BART'S *v.* ST. THOMAS'S.
REPLAYED TIE.

This replayed match duly came up at Richmond on March 8th, when we, after a most uninteresting game, suffered defeat by a goal and two tries to *nil*.

It would hardly be too much to say that, with about two exceptions, none of our men played up to anything like their best form, whereas *Thomas's* from the very first seemed to feel they had the game in hand, and played accordingly; the passing amongst their backs being at times really brilliant, while our forwards, who were thought so good, went completely to pieces after the first few minutes.

Thomas's, as before, lost the toss and kicked off against a stiffish breeze. The kick was well returned into touch about halfway, when a series of scrimmages resulted in a gain to neither party. *Bart's* were then given a free kick for an infringement of the off side rule by *Rotherham*, which gained us some ground. *Thomas's* then pulled themselves together, and, screwing the scrums in fine style, rushed the leather down into our twenty-five, *Maturin* and *Hawkins*, who throughout played a sound game, alone preventing a score. From some loose play the ball came out hard to *Body*, who fumbled it badly, and was collared before he could get in his kick. Some exciting play then took place on our line, and *Cruddas* several times saved grandly, a kick over the line by *Rotherham*, followed by a touch down, affording us temporary relief. After the kick-off *Thomas's* quickly returned to the assault, and it was only the continued good tackling of *Wilson*, *Cruddas*, and the halves which saved a try. *Greig* soon after had a drop at goal, but the ball went under the bar, and *Body* touched down. After this *Thomas's* simply swarmed to the attack, and a grand bout of passing, during which the ball travelled rapidly from *Rotherham* to *Grieg*, to *Thorman*, and back, ended in the latter scoring a try far out on the right, which was not converted. *Andrew* kicked off, and *Moggeridge's* return was charged down. A series of close scrimmages then took place at halfway, *Maturin* and *Hawkins* putting in some tricky play, but were too well marked to be really dangerous. Another bungle by our back nearly let *Thomas's* in,

but half-time came with our opponents dancing about on our goal-line.

On the game being restarted *Bart's* seemed to have waked up, and they quickly rushed the ball down into *Thomas's* twenty-five, when some exciting play took place, *Maturin* and *Wilson* repeatedly trying to break through, while once *Mason* would have been over had he not unfortunately put one foot in touch.

We were, however, gradually pushed back, and from an open rush by their forwards *Rouillard* dribbled over the line, and scored the second try for *Thomas's* near the side line, *Rotherham*, who took the kick, landing a magnificent goal. Rain then began to fall, but did not appear to interfere with the play, for *Thomas's* outsiders were soon passing accurately amongst themselves and several times nearly scored; a free kick to *Bart's* brought no relief, and almost immediately afterwards *Thorman* had an abortive shot at goal resulting in a touch down.

Rotherham then made his mark, and had a place shot at goal, but the ball fell short, another touch down resulting. Soon afterwards, after some good passing amongst their three-quarters, *Greig* scored again for *Thomas's*, but the attempt at conversion was a failure. The rest of the game was of a scrambling nature, *Bart's* losing heart and *Thomas's* not exerting themselves, particularly the margin of eleven points to *nil* no doubt seeming sufficient for all practical purposes. *Andrew*, *Wilson*, *Fleming*, and *Cruddas* were the best of our forwards, which, as the game was played, is not saying much, and *Maturin* and *Hawkins* showed a good example to the outsiders.

Abernethian Society.



FEBRUARY 28th, 1895.—The sixteenth Ordinary Meeting of the Society was held. Dr. Chattaway read a paper on "Diffusion," which subject he had chosen on account of its importance in connection with all vital processes.

Dr. Chattaway first dealt with gaseous diffusion, and then with diffusion of liquids, and then went into the constitution of colloid membranes and the so-called membranes of precipitation.

Mr. Maidlow spoke of the importance and interest of the subject, and points of discussion were raised by Messrs. Currie, Smith, Maxwell, and Maidlow.

Dr. Chattaway replied, and the meeting terminated.

March 11th.—A Special General Meeting was held at 12.30 p.m.; the Secretary, Mr. Barron, in the chair. After the minutes had been read and confirmed, Mr. Maidlow brought forward a motion that Rule I should be altered so as to permit of the formation of a General Debating Society in connection with the Abernethian Society.

Mr. Smith seconded. Various amendments were brought forward, all of which as well as the original proposal were lost.

March 13th.—A Clinical Evening was held, Mr. E. W. Cross being in the chair. The minutes of the last meeting were read and confirmed; then the following cases were shown and discussed:

- i. By Mr. Paterson, a case of ulceration of the scrotum.
- ii. By Mr. Colby, a case of rodent ulcer.
- iii. By Mr. Auden, a case of acromegaly.
- iv. By Mr. Keown, a case of epispadias.
- v. By Mr. Lloyd, microscopic sections of an ossifying spindle-celled sarcoma.
- vi. By Mr. E. W. Cross, a case of real lengthening of the tibia after old tubercular disease of the upper epiphysis.
- vii. Mr. Maxwell showed a baby with lateral movements of head and nystagmus.
- viii. Mr. Maidlow showed a bag intended by Dr. Champneys for dilating the os in inducing labour. Mr. Maidlow also read notes of a complicated case of induced labour.

After a short discussion on the cases the meeting terminated.

March 18th.—The eighteenth Ordinary Meeting of the Society was held. Mr. Maidlow was in the chair. After the reading and confirmation of the minutes of the previous meeting the President called upon Mr. Jessop to read his paper entitled "Thirteen Years in the Dissecting Room."

He first read a most interesting and amusing letter from Mr. Luther Holden, who also spent a great many years as a demonstrator, and then narrated some of his own experiences, and ended by giving some excellent advice to men going up for examinations.

Afterwards Messrs. Maidlow, Shepherd, Eccles, and Meakin spoke, and the meeting terminated.

Smoking Concert.

N March 22nd a Smoking Concert was given in the Library by the Musical Society and the Smoking Concert Club. The use of the Library for the purpose was kindly granted by the Governors and the Medical Committee. Some years ago a series of excellent smoking concerts was given in the Library, and these were always very largely attended both by the Staff and the students. It is to be hoped this concert may prove the first of many more to be given at regular intervals during the Winter and Summer Sessions.

Owing to the death of Sir Wm. Savory it was found necessary to postpone the concert to a date inconvenient to many on account of the near approach of examinations, so that the attendance, although good, was considerably below that of former smoking concerts held in the Library.

The programme was a varied one. The orchestra, conducted by Mr. Metcalfe (Mus. Bac.), played four short pieces, the best of which was a Minuet and Trio (Mozart). Dr. West and Mr. Walton each sang two songs. Mr. Nunn, whose voice has very much improved, sang "Ho! Jolly Jenkin," and another song later. The comic element was represented by Messrs. Gale, Birdseye, and Powell. These were recalled, Mr. Gale in particular having to work hard to satisfy the demands made on him by his audience. Dr. Haydon played admirably two pieces on the violin. Mr. Walton gave a flute solo, and Mr. Forman two banjo solos, for one of which he was recalled.

There were about 150 present, amongst whom we were glad to notice many members of the Medical and Teaching Staff. The proceedings terminated at 11.10 p.m.

St. Bartholomew's Hospital Smoking Concert Club.

N March 9th the Smoking Concert Club brought a most successful season to a close with the last concert. The excellence of the concerts, musically considered, has been well maintained, thanks to the never-failing diligence of the hon. secretary, Mr. D. L. E. Bolton, who has shown the talents of a "Harris" in unearthing the first-class performers whose names have graced the programmes. Gale's songs have been the leading feature of the concerts, and his "latest," a parody on "The Lost Chord," which is perhaps his cleverest, has been very popular. The attendances have been good as a rule, though the influenza and inclement weather cut down the numbers in the latter part of the winter very materially. Unfortunately Mr. Bolton was unable to appear at the last concert, and his duties devolved on Mr. W. R. Stowe, the assistant secretary. The chairman also, Mr. P. O. Andrew, had retired to his country house to recoup after his arduous duties in the football field, and a bout of the "fiend." Mr. P. W. James occupied the vacant chair, and conducted efficiently. A pianoforte solo by Mr. J. Edgar opened the programme. A song, "When I bestow," sung by Mr. S. F. Smith, was welcomed and appreciated. Mr. F. Womack very kindly came several miles to sing the next song on the programme, "Gipsy John;" he was deservedly encored, and sang "The Yeoman's Bride." Mr. J. C. Powell, whose last appearance in Hospital festivities made so favourable an impression on the audience, sang "The Polka and the Choir-boy" with much success. Mr. L. C. Thorne-Thorne described deeds of daring in a humorous recitation, "The Wreck of the Steamship 'Puffin,'" and responded to an encore. Mr. G. S. Brassey very kindly filled one of the vacancies on the programme, singing "Blow, blow, thou winter wind," and got an enthusiastic encore. At this period all the available singers had been called upon; Mr. J. C. Powell came to the rescue with another song, "The Tin Gee gee," and an encore, and prevented a premature close. Then Mr. Dick Welch turned up, and infused new life into the proceedings with "Then we had another one," sung in his irresistible style; a vociferous encore brought him on to the stage again to sing "Her golden hair was hanging down her back."

Mr. J. Edgar opened the second part with a piano solo, "French Dances from 'Henry VIII.'" Another vacant place was taken by Mr. Styles, who sang "What a funny sensation!" emphasising his text with facial gymnastics of a high order; in response to an encore he sang "The Girl in the Ulster." Then followed one of the best things of the evening, imitations of popular actors, by Mr. Algernon Newark; the club is indebted to this clever mimic for his excellent turn. On being recalled he recited "The Penny Reading" inimitably.

Mr. S. F. Smith sang another song, "Gallants of England," as well received as his first. Mr. Lane gave valuable assistance in the completion of the programme, and sang "Stammering Sweethearts" and "The Judge" in his well-known style. Mr. Brassey received an encore for his finished rendering of "The Lighthouse Keeper." Mr. Styles, to the fore again, sang "So was I" and "Always be cheerful" amid great applause. Mr. Brassey gave another song, "Honey, my honey," and then Mr. Styles "Had dozens of 'em," and had none too much room on the stage for his antics. Mr. Lane kindly took the last turn, and sang "I was justified in doing it." "Auld Lang Syne" terminated a successful concert. Mr. Howard Marsh was present amongst the visitors.

Interviews with Distinguished People.*

SIR DYCE DUCKWORTH.



E met the Editor in the square. He said, "Good morning." As the Editor does not as a rule recognise us in any way, we naturally were somewhat anxious to know how much he wanted to borrow. "Our paper," said he, "ought to be 'up to date.'" We don't care for the expression "up to date," but we let it pass, and merely remarked, "True," after the manner of a distinguished surgeon; and the Editor continued, "Have you noticed," said he, "that we are without one of the great attractions of modern journalism?" We said that there were several promising methods of gaining popularity that we appeared to have missed,—for instance, the insurance coupons. He might insure purchasers against death from post-mortem wounds or death from old age while waiting the convenience of the "lift" porters. But he said "no," that was not the idea; so we gave it up. "Well," said he, striking one of those favourite attitudes of his, "what about the illustrated interview dodge?" and he beamed down on us over his glasses. We remarked that ours was not an illustrated paper. "But that does not prevent us from having the interview without the illustrations," said he. We saw the force of this remark, and merely scratched our chin.

"We want interviews," said he, "and we mean to have them."

"And who is going to do the interviewing?" we asked.

"You are," he replied.

We endeavoured to laugh, but we felt uneasy.

"What you've got to do," said he, "is to get hold of a senior physician or surgeon, and just ask him questions like all the other interviewers do, and then write out the result for the JOURNAL."

"Yes, but suppose the senior physician or surgeon, instead of talking to us, merely drops us into the fountain; what then?" we asked.

"Oh, you must risk that," said the Editor.

We have great regard for the Editor, but we must admit that our affection for him is not of so virulent a type that we would be deposited in the fountain for his sweet sake, so we told him that we would *not* risk it.

But there, you know what arguing with the Editor is like—we were his slave in five minutes.

"You can't do better than begin to day," said he; "collar the first carriage that comes in [we don't know how to set about *collaring* a carriage], and tackle its occupant" ("collar" and "tackle,"—this is what comes of having a football editor.)

He then shook hands and left us. He seemed to think it a joke, but personally we did not grasp the humour of the idea. There we were, with a pretty sort of contract on our hands, and we prayed fervently that the first carriage might contain a patient and God-fearing man, who would not be easily provoked into an assault.

Thus we waited; it was worse than waiting for a "Viva," although in this case we had to do the examining.

Soon the great gates swung open, and a brougham drawn by a pair of dashing bays came rattling into the square.

Our heart jumped into our mouth, and the pericardium hitching over a broken tooth, we had some little difficulty in getting it back into the chest again, which naturally increased our nervousness. However, we dashed for the carriage, and just met the occupant as he was shutting the door.

It was Sir Dyce Duckworth! We hadn't the slightest notion how to begin, so we said "Good morning," which, after all, wasn't much of a thing to say, considering it was in the afternoon.

Sir Dyce stared at us, and asked to be favoured with our business.

"We are a student," we remarked.

[* We think it as well to state publicly that we do not hold ourselves responsible for any of the statements which appear in this contribution.—Ed.]

"Indeed," said Sir Dyce, who had probably never met us before; "and what do you study?" This rather stumped us for the moment, but we managed to convey the information that just at that present moment we were bringing our mighty intellect to bear upon the science of medicine, and asked if we could have a few words in private with him.

"Certainly," said he, and we strolled along the pavement together. "What do you consider to be the best method of learning medicine, Sir Dyce?" we asked.

He replied by asking us another.

"What is the best method of learning geography?" said he.

We said we thought the most promising plan was to buy an atlas and a book upon the subject, and then master their contents.

"Pooh!" said he. "Not at all. Travel; go all over the world, in and out and everywhere; leave no place unexplored, but" (here he held up his finger and then tapped his forehead) "use your memory—use your intelligence; that is the way to learn geography. Travel? Yes. Books?"—here he spread out both hands and shook his head ominously, from which we gathered he did not take kindly to books.

We do not care much for geography books ourselves, so that we were pleased to discover this bond of sympathy between ourselves and the distinguished physician.

There seemed to be a hitch in the proceedings after this, and Sir Dyce turned as if to depart, but we grabbed him and asked him what he thought of the weather. He turned round on us with a curious smile, felt our pulse, and asked us whether it came on suddenly or had we any premonitory symptoms. Did we feel dizzy at all? and had we suffered from headache? We said we never felt better in our lives. He then laid his hand on our shoulder, and gave us advice. We cannot remember all he said, but we gathered that, in his opinion, the abuse of alcohol was one of the banes of student life, and he dwelt at considerable length upon the impropriety of turning up at the hospital before the effects had fully cleared away.

We felt that things were not going so smoothly as could be wished, so we seized his hand, shook it heartily, and disappeared among the crowd around the fountain.

On looking back we observed Sir Dyce to be still rooted to the ground, gazing hopelessly in our direction.

He then shook his head, spread his hands out as if to thrust the atmosphere from him, tapped his forehead with his forefinger, shrugged his shoulders, and retired into the wards.

From which we concluded that Sir Dyce was in the act of considering us to be demented.

F. W. G.

I Reverie.

By a departing H. P.

SCENE: 1.30 a.m.—Friends have just gone, and the last "Good-bye, old chap; good luck," has been said. I lie back in my arm-chair with half-closed eyes. Nodding, "nearly napping," almost feeling the presence of some "ghastly grim ungainly raven" gazing through my soul as my fire flickers out its last, and a disturbed flow of thoughts courses through me, and I meditate thus to myself:—There cannot be many in the world who, with so few personal enemies, will quit their post so unceremoniously; few will be the thanks, fewer any actual signs of gratitude. None will miss me; and if they do, the blank will ere long be filled. Verily I am an unprofitable servant, I have only done my duty. To-morrow I shall be cast upon the world, no better off than when just qualified. Fame has been tasted, societies, clubs, messes, students have been led perhaps, but if I die to-morrow shall I be missed? They will say "he was not a bad chap" at the most, and feel their turn too will come. Verily, all is dust and ashes—*omnis vanitas, vanitas, vanitas*.

My raven now nods himself, my nodding becomes sleep, and sleeping, I dream. Home, sisters, music, gardens, and rivers seem to surround me, and my thoughts sit in the garden, and run into the music, and flow down the silvery stream with mother and sisters, saying now to me, "Who art thou, thou atom, to thus bemoan? Be thankful you have no foes. Why should you be missed, and are you not missed? You may have sown good seed you wot not of. You have tried to do your duty, and duty is happiness, and happiness is your proper object in life. Men associated with you may have derived good from you, and will swell the sum of total happiness amongst mankind. Have you not been privileged to soothe some poor patient's last hour? Have you not preserved a life of value to some one, and shown others how to do likewise? Have you not made friends and improved yourself by listening to the thoughts of others?

Has not your friend found a loving wife? And think what evil you *might* have done that you have not! Are *these* not matters for joy? You have, indeed, tasted fame; but better now than hereafter. *Now* you know its emptiness and vanity; you might have had yet to learn its barrenness. Now you have only to work to keep the wolf from the door, not to destroy yourself in the ceaseless toil for fame or fortune; you are to live for happiness, happiness obtained from duty-doing. This you have learnt to do. Do not, then, to-morrow play "Dead Marches" and cowardly melancholy music, or bemoan the vanity of existence. Do good, your duty to yourself, and fear not." "Sis justus et ne timeas."

I reflected then, or seemed to, upon our mess topics. Was I sufficiently paid? Previously I had said no, many times no. It was uncharitable, I said, sweating to obtain the most work at the lowest price; the poorest men were debarred from my enjoyments because of their poverty. Now Truth seemed to sing, "I shall prevail. Your life is a small speck in time, leave it to me; things will right, I shall prevail;" so I worked no more. The music said,—

"Ring in the love of truth and right,
Ring in the common love of good."

All myself seemed to be going; the good of me seemed to remain:

"The year is dying in the night,
Ring out, wild bells, and let him die."

My good remained, it seemed, and my successor came, I thought, and smiled no longer triumphantly at me:

"The year is going, let him go;
Ring out the false, ring in the true."

I murmured to him:

"Ring in the nobler modes of life
With sweeter manners, purer laws."

How glad I am to have been! how reconciled to go!

Here I awoke with a start. No more raven gloats on me, but a friend laughs at me, and the sickly odour of the ebbing lamp brings back earth to me. I am all the better for my reverie, and with some chaff to my dear friend I grumble off to my bedroom, needless to say in most admired disorder,—an emblem, indeed, of my brain—pessimism, optimism, indifference, joy, sorrow.

"Chaos, Cosmos! Cosmos, Chaos! who can tell how all will end?"

Read the wide world's annals, you, and take their wisdom for your friend."

MENS INSANA IN CORPORE VILI.

Junior Staff Appointments.

The following appointments have been made for six months, from April 1st:

HOUSE PHYSICIANS TO—

	SENIOR.	JUNIOR.
Dr. Church	F. H. Lewis, B.A., M.B., B.C.(Cantab.).	W. E. Lee, M.B. (Lond.), M.R.C.S., L.R.C.P.
Dr. Gee.....	B. Collyer, M.B. (Lond.), M.R.C.S., L.R.C.P.	J. K. Murphy, M.R.C.S., L.R.C.P.
Sir D. Duckworth ...	J. D. Rawlings, M.B. (Lond.), M.R.C.S., L.R.C.P.	J. B. Christopherson, B.A., M.B., B.C. (Cantab.).
Dr. Hensley.....	C. H. Perram, M.B. (Lond.), M.R.C.S., L.R.C.P.	K. Rogers, M.D. (Lond.), M.R.C.S., L.R.C.P.

HOUSE SURGEONS TO—

	SENIOR.	JUNIOR.
Mr. Smith	A. M. Mitchell, M.A., M.B., B.C.(Cantab.).	C. H. Drake, M.R.C.S., L.R.C.P.
Mr. Willett	F. Belben, M.A., M.B., B.C.(Cantab.), F.R.C.S.	L. C. P. Phillips, M.R.C.S., L.R.C.P.
Mr. Langton	T. A. Bowes, B.A., M.B., B.C.(Cantab.).	C. P. White, M.R.C.S., L.R.C.P.
Mr. Marsh	E. S. Humphrey, M.R.C.S., L.R.C.P.	F. Crossman, M.R.C.S., L.R.C.P.
Mr. Butlin	F. Fraser, M.R.C.S., L.R.C.P.	E. G. B. Adams, M.R.C.S., L.R.C.P.

MIDWIFERY ASSISTANT.—E. W. Cross, M.R.C.S., L.R.C.P.

EXTERN MIDWIFERY ASSISTANT.—R. Sevestre, M.A., M.B., B.C.
(Cantab.).

OPHTHALMIC HOUSE SURGEON.—F. E. A. Colby, B.A., M.B.,
B.C.(Cantab.).

Appointments.

COLBY, J. G. E., M.B.Oxon., F.R.C.S., has been reappointed Medical Officer of Health of the Malton Rural District, and of the Norton Rural District.

PALFORD, HERBERT, M.A., M.B.Cantab., has been appointed third Assistant Medical Officer to the Worcester City and County Asylum.

HAINES, J. W., M.B.Lond., M.R.C.S., L.R.C.P., has been appointed House Surgeon to the Belgrave Hospital for Children.

CURREY, E. F. N., L.R.C.P., M.R.C.S., has been appointed House Physician to the West London Hospital.

GAULT, E. L., M.A., M.B., who studied at "Bart.'s" for a few months three years ago, has been appointed Ophthalmic Surgeon to the Alfred Hospital, Melbourne.

PAGET, O. T., M.B., B.C.Cantab., has been appointed Resident Medical Officer to the St. George's and St. James's Dispensary, W.

DRAGE, LOVELL, M.D.Oxon., has been reappointed Medical Officer of Health to the Hatfield Rural Sanitary District.

MAIDLOW, W. H., M.B.Durh., F.R.C.S.Eng., has been appointed House Surgeon to the Taunton Hospital.

MEAKIN, HAROLD B., M.B.Lond., M.R.C.S., L.R.C.P., has been appointed Senior House Physician to the Metropolitan Hospital.

CALVERLEY, J. E. G., M.R.C.S., L.R.C.P., has been appointed Assistant House Surgeon to the Metropolitan Hospital.

PECK, W. G., who passed into the Naval Medical Service in November last, has been appointed Surgeon to H.M.S. "Pilot."

FISHER, OCTAVIUS S., L.R.C.S., L.R.C.P.Edin., who has been on leave to take advantage of the regulation permitting Naval Surgeons to study for a short time at a Hospital School, and has been a student of "Bart.'s" since January, has just been appointed Surgeon to the Jamaica Naval Hospital.

Pathological Department.

Bacteriology and Public Health.—Dr. Kanthack will begin the next course of Elementary Bacteriology in May. Gentlemen wishing to attend are requested to send in their names to Dr. Shore, Warden's House. Days and hours will be arranged subsequently.

The next course of Practical Bacteriology for the Diploma of Public Health will also commence in May during hours to be arranged later.

Dr. Kanthack requests those gentlemen who wish to take out either of these courses to meet him on May 2nd at 11 a.m. in the Pathological Laboratory, in order to settle the days and hours of work.

Course of Pathological Chemistry.—Dr. Kanthack will hold a class during the summer term in Pathological Chemistry. The class is intended for Research Clerks and advanced students (candidates for the M.B. of London, Oxford, or Cambridge). It will meet two afternoons during the week in the Pathological Laboratory, and will extend over six weeks (twelve meetings). A short syllabus is appended. The course is optional, and no fee is charged.

A. *Some special methods for the examination of urine.*

Uric acid, variations in the excretion of, in disease.

Quantitative estimation of uric acid in urine by the Gowland-Hopkins method (saturation with ammonium chloride).

Chlorides.—Variations in the amount of chlorides in urine. Estimation by Mohr's method.

Sugar.—The phenyl-hydrazin test for sugar in urine.

Diazo-reaction.—Ehrlich's diazo-reaction in the urine of enteric fever and tuberculosis.

Spectroscopy of urine.—Spectroscopic examination of the urine in hæmaturia and hæmoglobinuria.

Detection and extraction of urobilin and hæmatoporphyrin, tests for indigo in urine, Jaffe's test, spectroscopic examination of the products.

Proteids in urine.—Serum-albumen, paraglobulin, albumoses, conditions in which albumosuria occurs.

B. *Examination of serous fluids, fluid from cysts, hydatid fluid, &c.*
Serous effusions.—Colour, reaction, specific gravity, microscopic constituents.

Proteids.—Salts, coagulation, cholesterin.

Hydatid fluid.—Reaction, sp. gr., salts, hydatid hooklets and scolices.

Charcot's crystals.—In sputum of asthma, &c.

C. *Micro-chemistry of blood.*

Classification of leucocytes: basophile, oxyphile (eosinophile), and neutrophile corpuscles; their importance in disease and diagnosis. Anæmia.

Pathological Clerks.—As there are still several vacancies for May to July, gentlemen wishing to clerk in the Pathological Laboratory are requested to send in their names to the Lawrence Student of Pathology, Mr. J. W. W. Stephens, Pathological Laboratory.

Dr. Kanthack will give weekly instructions in practical histology, and weekly demonstrations in the minute morbid anatomy of the nervous system. These classes are strictly limited to the Pathological and Research Clerks.

Correspondence.

To the Editor of St. Bartholomew's Hospital Journal.

DEAR SIR,—In looking over the arrangements for the Conversation, to be given by the Abernethian Society on the 1st of May, I notice that the St. John's Ambulance Corps has been invited to give a display in the Dissecting Room.

I quite understand that a more excellent body could not have been chosen, but I beg to ask whether you do not think that it would have been more appropriate, as the celebration of the anniversary is essentially a hospital event, that No. 3 Company of the Volunteer Medical Staff Corps should have been given an opportunity of joining in the festival.

The Company is essentially a hospital one. There are sixty students in it, and it is officered by old Bart.'s men. Most, if not all, of these men are members of the Abernethian, and I think—indeed, am sure, would have welcomed an opportunity of taking part.

At the last moment a half-hearted offer of the Abernethian Room has been made, but was declined, as the "locale" is hardly suited for a display. With apologies for troubling you, I remain,

A MEMBER OF THE ABERNETHIAN SOCIETY
AND A VOLUNTEER.

April 8th, 1895.

Births.

DAVIES.—On March 17th, at Oakland Terrace, Cricklewood, N.W., the wife of H. O. Davies, M.D.(Lond.), of a son.

EDGE.—On March 16th, at Maidenhead, the wife of A. J. Edge, M.B.(Lond.), of a son.

STOCKER.—On March 12th, at Weedon, Northamptonshire, the wife of E. G. Stocker, M.R.C.S., L.R.C.P., of a son.

CUTCLIFFE.—On March 23rd, at North Tawton, Devon, the wife of Montagu Cutcliffe, M.R.C.S., L.R.C.P., of a daughter.

Marriages.

MAC-ALISTER.—MACALISTER.—On Tuesday, March 19th, at St. Columba's Presbyterian Church, Cambridge, by the Rev. A. Halliday Douglas, M.A., assisted by the Rev. Alex. Connell, of Regent Square Church, London, Donald Mac-Alister, M.D., Fellow of St. John's College, Cambridge, to Edith Florence Boyle, elder daughter of Professor Alexander Macalister, of Torrisdale, Cambridge.

SETON.—ARMSTRONG.—On March 16th, at Southsea, Surg.-Capt. Seton, I.M.S., to Elma, daughter of Lieut.-Colonel F. H. Armstrong, Southsea.

Deaths.

TAUNTON.—On February 10th, at 36, Beaumont Street, Oxford, George Taunton, Esq., M.R.C.S.Eng., third son of the late Daniel Taunton, Esq., of Walton House, St. Giles, aged 70 years. Interment at St. Sepulchre's Cemetery on Saturday, 23rd inst., at two o'clock.

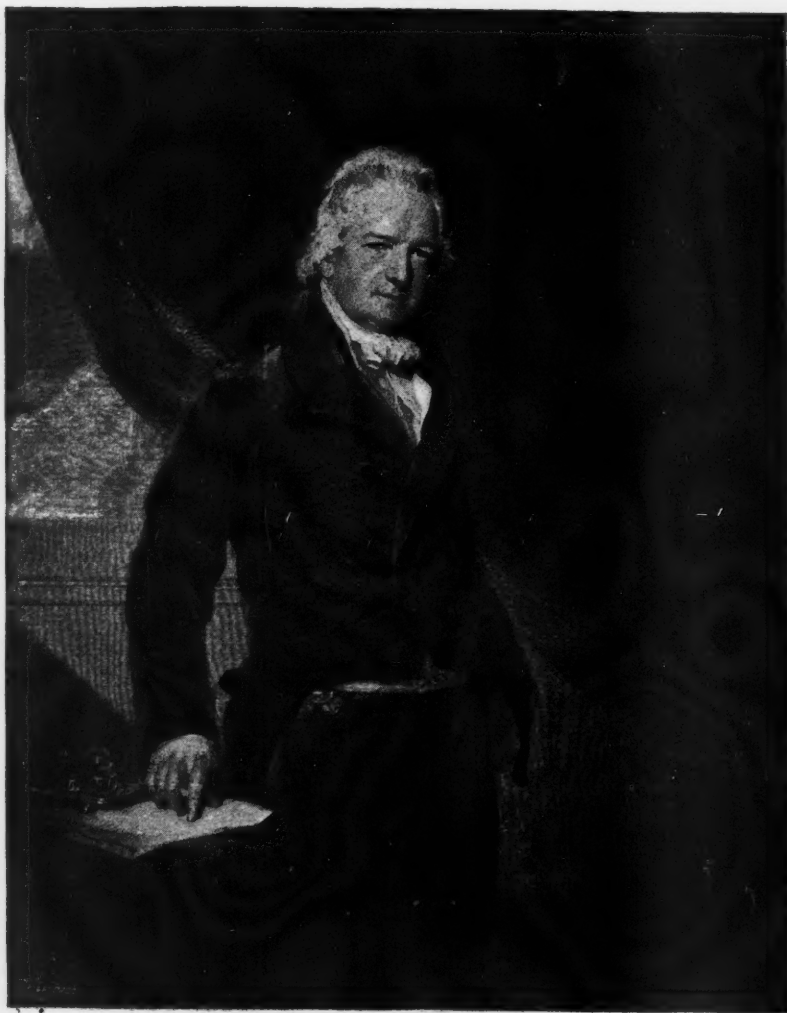
EARDLEY-WILMOT.—On April 6th, suddenly, of heart disease, Chester Eardley-Wilmot, M.D., B.S.Durh., Senior Assistant Medical Officer at Middlesex County Asylum, in his twenty-eighth year. He was formerly Assistant Electrician at St. Bart's.

REEKS.—On April 5th, suddenly, at Southwick, Sussex, John Reeks, M.R.C.S., L.S.A., aged 38.

ACKNOWLEDGMENTS.—*Guy's Hospital Gazette.* *St. Thomas's Hospital Gazette.* *St. Mary's Hospital Gazette.* *Handbook of the Clinical Research Association.* *Hospital Service Book*, by C. PARKHURST BAXTER (Oxford University Press).

Abernethian Society of St. Bartholomew's Hospital.

CENTENARY, MAY 1ST, 1895.



Adlard Imp.

JOHN ABERNETHY, ESQ., F.R.S.

Surgeon to St. Bartholomew's Hospital and Lecturer on Anatomy and Surgery.

Reproduced from the Picture by Sir Thomas Laurence, P.R.A., in the Great Hall of St. Bartholomew's Hospital.

St. Bartholomew's Hospital Journal.

14th May, 1895.

